Bureau of Insurance

A Report to the Joint Standing Committee on Banking and Insurance of the 120th Maine Legislature

Review and Evaluation of
LD 323, an Act Concerning Patient Access to Eye Care Providers

May 9, 2001

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I. Executive Summary

The Joint Standing Committee on Banking and Insurance of the 120th Maine Legislature directed the Bureau of Insurance to review LD 323, an Act Concerning Patient Access to Eye Care Providers. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752. This review was a collaborative effort of MMC (MMC Enterprise Risk Consulting, Inc.) and the Bureau (Maine Bureau of Insurance).

LD 323 would amend sections of Maine law pertaining to individual and group health insurance plans. Appendix A includes the proposed amendments to the applicable sections of Maine law. This bill would require that all health plans and managed care plans that cover eye care services to provide direct access to any participating eye care provider (optometrist or ophthalmologist). Participating eye care providers must be included on the plan's list of participating providers. Covered eye care benefits must be provided without discrimination between classes of eye care providers. Additionally, LD 323 prohibits health plans from imposing a deductible or coinsurance greater than those applied to other covered services. Health plans cannot require eye care providers to have hospital privileges as criteria for participation. LD 323 does not require coverage for any services that are not otherwise covered under the terms of the health plan. The proposed law does not require health plans to allow participation of any willing eye care provider. LD 323 does not prohibit a covered person from seeking eye care services from the enrollee's primary care physician (PCP). A health plan may require prior approval for any subsequent surgical procedures.

LD 323 would only materially alter health plans that require a referral by a PCP in order to have insurance coverage for a visit to an optometrist or ophthalmologist. For some plans, the deductible and coinsurance may require adjustment to comply with the proposed mandate. The cost of such adjustments would be negligible since eye care visits comprise a very small fraction of the total benefit cost.

Similar legislation was proposed in LD 414, An Act to Require Health Maintenance Organizations to Cover Optometrist Services. LD 414 had additional requirements for HMO's to include coverage for services by optometrists. Also, it would have added optometrists to the list of required providers that HMO's have to include in their panel.

While the Maine Optometric Association indicated in written comments that all HMOs in Maine currently accept doctors of Optometry, they were concerned that they had no protection from being excluded in the future.

Similar legislation has been passed in two other states, Tennessee and Colorado. Tennessee limits direct access to one visit per year. Colorado's legislation is similar to that proposed by LD 323. The only difference in the Colorado bill is it that the law specifically states that the intent is not to increase or decrease the scope or the practice of optometry. Neither state had information regarding the cost impact of mandating the benefit.

Under the concept of managed care, a PCP is responsible for managing the care of patients. Patient referrals to specialists are an essential aspect of managed care. This care management is intended to reduce the inappropriate use of medical services and to ensure that quality medical services are provided in the most cost effective setting by the most cost effective provider. Managed care organizations view care management as the core ingredient to both controlling the cost and ensuring the quality of services provided under their health plans. Removing categories of care from the control of PCP's will, in the opinion of insurers, reduce the effectiveness of managed care. National studies and surveys from a variety of sources report that premiums for managed care plans are below those of comparable health plans without managed care.
Proponents of LD 323 argue that allowing direct access to optometrists and ophthalmologists may increase the use of professionals and equipment that are more effective in diagnosing and treating eye care conditions. Optometrists and ophthalmologists have equipment that is not generally available in the offices of PCPs. Some proponents also believe that the time spent to get a referral from a PCP makes the system more inefficient and costly than allowing direct access.

The Bureau surveyed the primary insurers in Maine. These included Aetna U.S. Healthcare, Anthem Blue Cross Blue Shield of Maine, CIGNA, Harvard Pilgrim Health Care, United Healthcare and Maine Partners Health Plan. Four health insurers that responded to the survey do not require a referral for routine eye examinations. All of the responding insurers expressed a concern that LD 323 would diminish the capacity of PCP's to manage their members' care.

Estimates, provided by the responding insurers, of the impact of LD323 on premiums varied from no impact to a 0.4% increase. MMC estimates that insurance premiums for managed care plans that require PCP approval for access to optometrists or ophthalmologists may increase by 0.04%. The magnitude of this premium increase by itself would not seem sufficient to move health insurance purchasers to discontinue coverage. However, recent average annual premium increases for health insurance have exceeded 10% for employer groups. Individual premium increases have been as high as 64%.[1] The premium increase estimated for LD 323 when combined with large renewal increases could intensify the consumer's sensitivity to the escalation in health insurance costs.

[1] White Paper: Maine's Individual Health Insurance Market, Updated January 22, 2001

II. Background

The Joint Standing Committee on Banking and Insurance of the 120th Maine Legislature directed the Bureau of Insurance to review LD 323, an Act Concerning Patient Access to Eye Care Providers. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752. This review was a collaborative effort of MMC Enterprise Risk Consulting, Inc. and the Maine Bureau of Insurance.

The proposed mandate would amend sections of Maine law pertaining to individual and group health insurance plans. Appendix A includes the proposed amendments to the applicable sections of Maine law. The provision requires all health plans and managed care plans offered by a carrier that provide coverage for eye care services to:

- Provide direct access to any eye care provider (optometrist or ophthalmologist) participating and available under the plan for eye care services,
- Include eye care providers in any publicly accessible list of participating providers for the health plan, and
- Not discriminate between classes of eye care providers that provide services permitted by the provider's license.

The provision prohibits health plans from:

- Imposing deductibles or coinsurance for eye care services that are greater than those for other medical services, or
- Requiring an eye care provider hold hospital privileges as a condition of participation under the health plan.

The provision does not:

- Require coverage for any service that is not otherwise covered under the terms of the health plan,
- Require a health plan to include as a participating provider every willing provider,

- Prevent a covered person from seeking eye care services from the enrollee's primary care provider,
- Require eye care services to be provided in a hospital or similar medical facility, or
- Prohibit a health plan from requiring an enrollee to receive a referral for prior authorization from a primary care provider for any subsequent surgical procedures.

Currently, many managed care plans require that individuals obtain a referral from their primary care physician (PCP) to visit an optometrist or ophthalmologist for other than routine eye care. Some individuals with eye problems proactively request referrals to an optometrist or ophthalmologist and others go to their PCP, who then determines if a referral is necessary. A survey, submitted as testimony by the Maine Optometric Association, suggests that if the patient requests a referral that it is usually provided by the primary care physician. One individual testified that only after the treatment recommended by the PCP was ineffective did he request a referral. The referral was quickly provided, but the process delayed the patient from receiving the appropriate treatment. MMC and the Bureau were unable to acquire comprehensive and reliable studies to determine the frequency of these occurrences.

A representative from one health center, a proponent of the bill, testified that the process of requiring patients to visit their family practitioners, rather than going directly to an optometrist or ophthalmologist is inefficient and delays getting the proper treatment. MMC and the Bureau were unable to acquire clinical studies to affirm or refute this conclusion.

The Maine State Chamber of Commerce, an opponent of the bill, testified that their membership is concerned with the escalating cost of health care insurance. There is a concern that increases due to mandated benefits on top of already increasing premiums will cause employers to drop their coverage thus increasing the number of uninsured. Health insurers, based on testimony and responses to the survey conducted by the Bureau, view LD 323 as another in a series heath insurance mandates that will further erode their capacity to manage the cost and quality of patient care.

Similar legislation was proposed in LD 414, An Act to Require Health Maintenance Organizations to Cover Optometrist Services. LD 414 had additional requirements for

HMO's to include coverage for services by optometrists. Also, it would have added optometry to the list of required providers that HMO's have to include in their panel. While the Maine Optometric Association indicated in written comments that all HMOs in Maine currently accept doctors of Optometry, they were concerned that they had not protection from being excluded in the future.

III. Social Impact

A. Social Impact of Mandating the Benefit

1. The extent to which the treatment or service is utilized by a significant portion of the population.

Eye care examinations are recommended for everyone at some point in their life although less than 20% of individuals visit an optometrist or ophthalmologist in a given year. If a person does not have vision or physical eye problems early in life, most people start to have changes in their vision in their 40s that would require vision testing. Thus, utilization will increase as the average age of the population increases.

2. The extent to which the service or treatment is available to the population.

There are 180 optometrists and 50 to 60[2] ophthalmologists licensed in the state of Maine. Most citizens of Maine have access to these eye care providers.

3. The extent to which insurance coverage for this treatment is already available.

For those covered by a managed care health insurance contract, an individual may need a referral from his or her PCP in order to be covered for the services of an optometrist or ophthalmologist. The Maine Optometric Association conducted a non-scientific survey. Twenty-five primary care providers in the Fort Kent, Bangor, Lewiston and Western Maine areas were surveyed in March 2001. The survey asked: "If one of your patients called your office requesting a PCP referral to their local ophthalmologist or optometrist for an acute eye problem (such as vision loss, red and painful, eye injury, etc.), how likely would you be to approve the referral?" Of the 25 PCPs 18 (72%) said "Almost Always", 5 (20%) said "Frequently", 1 (4%) said "Occasionally" and 1 (4%) said "Seldom". This suggests that there is considerable unimpaired access to eye care benefits under managed care plans. Also, health plans are available that do not impose referral

[2] Maine Optometric Association

requirements on any benefits.

4. *If coverage is not generally available, the extent to which the lack of coverage results in a person being unable to obtain the necessary health care treatment.*

Health care treatment is currently available for medical problems of the eye. If an individual is enrolled in a managed care plan, care is available through the individual's PCP or through a referral to an optometrist or ophthalmologist.

5. *If coverage is not generally available, the extent to which the lack of coverage involves unreasonable financial hardship.*

Currently, if an individual is enrolled in a managed care plan, they may need to contact their PCP to get a referral to an optometrist or ophthalmologist. There should not be an unreasonable financial hardship.

6. *The level of public demand and the level of demand from providers for this treatment or service.*

Representatives of the Maine Optometric Association and eye care providers testified that they support LD 323.

7. *The level of public demand and the level of demand from the providers for individual or group coverage of this treatment.*

Individuals expressing support for direct access to optometrists or ophthalmologists gave testimony.

8. *The level of interest in and the extent to which collective bargaining organizations are negotiating privately for the inclusion of this coverage by group plans.*

No information is available.

9. *The likelihood of meeting a consumer need as evidenced by the experience in other states.*

Similar legislation for direct access to optometrists or ophthalmologists has been passed in Tennessee and Colorado. However, sufficient experience has yet to be accumulated to assess the impact on cost or access. These states do not intend to study the impact of the mandate given its minimal anticipated cost.

Tennessee provides for one annual self-referred visit for vision care services as well as services and necessary follow-up care related to the treatment.

Colorado's law is similar to LD 323. It requires that a health plan or managed care plan, that provides coverage for eye care services, to permit a covered person direct access to any eye care provider participating and available under the plan or through its eye care services intermediary. Like LD 323, Colorado requires that a health plan include all eye care providers on a health plan's list of participating providers. Colorado's law has the same prohibitions as LD 323 and the same elements that are not specifically required. Additionally, Colorado specifically states that the intent is not to change the scope of the practice of optometry.

10. *The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.*

State agencies did not provide findings pertaining to the proposed legislation.

11. *Alternatives to meeting the identified need.*

Individuals and employers can now purchase health plans that do not require referrals for eye care.

12. *Whether the benefit is a medical or a broader social need and whether it is inconsistent with the role of insurance and the concept of managed care.*

The benefit is not inconsistent with the role of insurance.

The concept of managed care gives a PCP the responsibility for managing the care of patients and is based on a close relationship between a patient and their PCP. Managed care often requires individuals to obtain prior approval from their PCP for medical services beyond those provided by the PCP. This is intended to reduce the inappropriate use of medical services and to ensure that quality medical services are provided in the most cost effective setting by the most cost effective provider. Opponents of LD 323 are concerned that less controlled access to specialists interferes with the relationship between patients and their PCPs.

National studies and surveys from a variety of sources report that premiums for managed care plans are generally below than those of comparable health plans without managed care.[3]

13. *The impact of any social stigma attached to the benefit upon the market.*

There is no social stigma attached to receiving care from a optometrist or ophthalmologists.

[3] Sources include reports published by AAHP and Merrill Lynch/Howard Johnson Company

14. *The impact of this benefit upon the other benefits currently offered.*

Currently managed care contracts expect PCPs to manage most medical care including eye care. LD 323 would modify the way managed care plans operate and the way PCPs manage care by allowing direct access to optometrists and ophthalmologists. The PCP may not be aware of all services being provided and the complete medical condition of the patients that he or she is responsible for.

15. *The impact of the benefit as it relates to employers shifting to self-insurance and the extent to which the benefit is currently being offered by employers with self-insured plans.*

State legislation that imposes benefit mandates will heighten an employer's concern with regard to future costs and their ability to control those costs, which makes self-insurance a more attractive alternative. The 1998 Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans indicates that 36% percent of the large employers (500 or more employees) in the Northeast self-insure health plans.

Given the double digit annual increases in medical care costs, large employers may be particularly sensitive to any legislation that places limits on managed care and increases the cost of health care.

No information is available as to the extent to which this direct access to optometrists or ophthalmologists is currently being offered by employers with self-insured plans.

16. *The impact of making the benefit applicable to the state employee health insurance program.*

Anthem Blue Cross Blue Shield indicates that this mandate will affect their point of service plans in Maine and would increase premiums by .1% to .2%.

IV. Financial Impact

B. Financial Impact of Mandating Benefits.

1. The extent to which the proposed insurance coverage would increase or decrease the cost of the service or treatment over the next five years.

The increase in optometrists or ophthalmologists visits is not anticipated to increase demand sufficiently or have an effect on the cost of services over the next five years.

2. The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years.

LD 323 may increase the use of eye care professionals for the treatment of eye conditions due to expanded access.

3. The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.

It is possible that optometrists or ophthalmologists office visits will replace less expensive PCP office visits. Alternatively, it is possible that going directly to an optometrist or ophthalmologist could result in more expeditious and less costly eye care.

4. The methods which will be instituted to manage the utilization and costs of the proposed mandate.

There would be no management of direct access to optometrists and ophthalmologists services for initial or subsequent office visits.

5. *The extent to which insurance coverage may affect the number and types of providers over the next five years.*

An estimate provided by the Maine Optometric Association indicates that the appropriate number of optometrists is 1 for every 7,000 Maine residents and of ophthalmologists is 1 for every 21,000 Maine residents. Based on Maine's population of 1,274,923 the appropriate number of optometrists or ophthalmologists would be approximately 182 and 61 respectively. There are approximately 180 optometrists and 60 ophthalmologist licensed in the State of Maine. Given the limited scope of LD 323, it is unlikely to materially change the number of eye care providers in Maine.

6. *The extent to which the insurance coverage of the health care service or providers may be reasonably expected to increase or decrease the insurance premium or administrative expenses of policyholders.*

Insurance premiums for managed care plans that require PCP approval for access to optometrists or ophthalmologists are estimated to increase by 0.04%. If decreasing the management of eye care by PCPs actually increases the utilization of eye care health services and therefore increases costs significantly more than expected, premium increases could be higher. Table A displays the calculations. It is important to note that the calculations presume that the PCPs are reimbursed based on capitation. Capitation is a fixed monthly fee per covered member as opposed to reimbursement for each service actually performed. As result, reduced visits to the PCP due to direct access do not produce direct savings for managed care plans. If PCPs are reimbursed on a fee-for-service basis, as they are in more and more Maine managed care plans, the elimination of the PCP visit could be a savings to the managed care plan.

TABLE A ESTIMATED IMPACT ON MANAGED CARE PLAN PREMIUM			
A	Annual eye care visits per 1,000 members	170	Includes visits to optometrists and ophthalmologists (MMC databases)
B	Percent of eye care visits disallowed by PCP	10%	Estimate
C	Cost per visit less copay	$47	MMC databases
D	Cost per member per month	$.07	A x B x C / 12,000
E	Total monthly benefit cost per member	$170	MMC databases
F	Percent premium increase	0.04%	D / E

Anthem Blue Cross Blue Shield estimates that insurance premiums for small group and individual plans may increase 0.2% to 0.4% in general. CIGNA does not expect that LD 323 will increase insurance premiums.

The section of LD 323 prohibiting plans from imposing deductibles or coinsurance for eye care services that are greater than those for other medical services will have limited financial impact since plans do not typically impose greater deductibles and coinsurance for eye care services.

7. *The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the cost and benefits of coverage.*

There would not be any additional cost effect beyond premium increases for managed care plans.

8. *The impact on the total cost of health care.*

Because the only potential cost effect of LD 323 is for managed care plans that require PCP approval for access to optometrists or ophthalmologists, the impact on the total cost of health care would be less than .04%.

9. *The effects on the cost of health care to employers and employees, including the financial impact on small employers, medium-sized employers and large employers.*

On average, LD 323 would increase premiums for managed care health plans that require PCP approval for access to optometrists or ophthalmologists by an estimated 0.04%. Employers will pay this additional premium as will employees to the extent the cost is passed on through the employee's financial contribution to the premiums. There is no reason that the estimated percentage premium increase will vary for small employers, medium-sized employers and large employers. This increase will contribute to rising premiums that may cause employers who are too small to self-insure to discontinue offering health insurance to employees. Fewer employees may elect health insurance when confronted with rising premiums.

V. Medical Efficacy

C. The Medical Efficacy of Mandating the Benefit.

1. The contribution of the benefit to the quality of patient care and the health status of the population, including any research demonstrating the medical efficacy of the treatment or service compared to the alternative of not providing the treatment or service.

Research on the medical efficacy of treatment of eye conditions by an optometrist or ophthalmologist compared to a general practitioner is not generally available. Testimony indicates that specialized diagnostic equipment used by optometrists and ophthalmologists is not generally available to or used by general practitioners. Anecdotal information indicates that some eye conditions would have been more accurately diagnosed and treated by an eye care specialist than by a PCP.

2. If the legislation seeks to mandate coverage of an additional class of practitioners relative to those already covered.

a. The results of any professionally acceptable research demonstrating medical results achieved by the additional practitioners relative to those already covered.

LD 323 does not mandate coverage of an additional class of practitioners.

b. The methods of the appropriate professional organization that assure clinical proficiency.

LD 323 does not mandate coverage of an additional class of practitioners.

VI. Balancing the Effects

D. The Effects of Balancing the Social, Economic, and Medical Efficacy Considerations.

1. The extent to which the need for coverage outweighs the cost of mandating the benefit for all policyholders.

Insurance premiums for managed care plans that require PCP approval for access to optometrists or ophthalmologists may increase by approximately 0.04%. Testimony indicates that specialized diagnostic equipment used by optometrists and ophthalmologists is not generally available to or used by general practitioners. Anecdotal information indicates that some eye conditions would have been more accurately diagnosed and treated by an eye care specialist than by a PCP. Research did not uncover clinical studies to assess the cost implications of or medical efficacy associated with direct access to eye care providers.

State legislation that imposes benefit mandates will heighten an employer's concern with regard to future costs and their ability to control those costs, which makes self-insurance a more attractive alternative. The 1998 Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans indicates that 36% percent of the large employers (500 or more employees) in the Northeast self-insure health plans.

Given the double digit annual increases in medical care costs, employers may be particularly sensitive to any legislation that places limits on managed care and increases the cost of health care.

2. *The extent to which the problem of coverage can be resolved by mandating the availability of coverage as an option for policyholders.*

Coverage options are currently available to employers and individual purchasers. However, employees are limited to the health plan offered by their employer.

3. *The cumulative impact of mandating this benefit in combination with existing mandates on costs and availability of coverage.*

The Bureau's estimates of the maximum premium increases due to existing mandates and the proposed mandate are displayed in Table B.

TABLE B
MAXIMUM PREMIUM INCREASES

	Group (more than 20 employees)	Group (20 or fewer employees)	Individuals
CURRENT MANDATES			
▪ Fee-for-Service Plans	7.84%	3.94%	3.93%
▪ Managed Care Plans	7.52%	4.02%	3.92%
LD 323			
▪ Fee-for-Service Plans	.00%	.00%	.00%
▪ Managed Care Plans	.04%	.04%	.05%
CUMULATIVE IMPACT			
▪ Fee-for-Service Plans	7.84%	3.94%	3.93%
▪ Managed Care Plans	7.56%	4.06%	3.96%

These increases are based on the estimated portion of claim costs that the mandated benefits represent, as detailed in Appendix B. The true cost impact is less than this for two reasons:

1. Some of these services would likely be provided even in the absence of a mandate.
2. It has been asserted (and some studies confirm) that covering certain services or providers will reduce claims in other areas. For instance, covering mental health and substance abuse may reduce claims for

physical conditions. Covering social workers may reduce claims for more expensive providers such as psychiatrists and psychologists. Covering chiropractic services may reduce claims for back surgery. Covering screening mammograms may reduce claims for breast cancer treatment.

While both of these factors reduce the cost impact of the mandates, we are not able to estimate the extent of the reduction at this time. While some studies have estimated much higher costs for mandated benefits, these studies were not based on the specific mandates applicable in Maine and therefore are not relevant. There is no indication that mandated benefits have impacted the availability of health insurance.

VII. Appendices

Appendix B: Cumulative Impact of Mandates

Following are the estimated claim costs for the existing mandates without the reductions:

- ***Mental Health*** - The mandate applies only to groups of more than 20. The amount of claims paid has been tracked since 1984 and has historically been in the range of 3% to 4% of total group health claims. Mental health parity for listed conditions was effective 7/1/96. The 1998 data showed a small increase to 3.43% of total group health claims while 1999 data showed a slight increase to 3.49%. We have used 3.5% as our best estimate for future years.

- ***Substance Abuse*** - The mandate applies only to groups of more than 20 and does not apply to HMOs. The amount of claims paid has been tracked since 1984. Until 1991, it was in the range of 1% to 2% of total group health claims. This percentage has shown a downward trend beginning in 1989 and continuing through the most recent data points which were 0.4% for 1998 and 0.39% in 1999. This is probably due to utilization review, which has sharply reduced the incidence of inpatient care. Inpatient claims have decreased from about 90% of the total to about 56%. We estimate the percentage to remain at about the 0.4% level, although further decreases are possible.

- ***Chiropractic*** - The amount of claims paid has been tracked since 1986 and has been approximately 1% of total health claims each year. However, the trend has been increasing since 1994. The percentage has increased from 0.84% that year to 1.29% in 1998 and 1.46% in 1999. We therefore estimate 1.6% going forward.

- ***Screening Mammography*** - The amount of claims paid has been tracked since 1992 and generally has been in the range of 0.2% to 0.3%. It was 0.3% in 1998 and 0.31% in 1999 which may reflect increasing utilization of this service. We estimate 0.3% going forward.

- ***Dentists*** - This mandate requires coverage to the extent that the same services would be covered if performed by a physician. It does not apply to HMOs. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- ***Breast Reconstruction*** - At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.20 per month per individual. We have no more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.

- ***Errors of Metabolism*** - At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.10 per month per individual. We have no more recent estimate. We include 0.01% in our estimate.

- ***Diabetic Supplies*** - Our report on this mandate indicated that most of the 15 carriers surveyed said there would be no cost or an insignificant cost because they already provide coverage. One carrier said it would cost $.08 per month for an individual. Another said .5% of premium ($.50 per member per month) and a third said 2%. We include 0.2% in our estimate.

- ***Minimum Maternity Stay*** - Our report stated that Blue Cross did not believe there would be any cost for them. No other carriers stated that they required shorter stays than required by the bill. We therefore estimate no impact.

- ***Pap Smear Tests*** - No cost estimate is available. HMOs would typically cover these anyway. For indemnity plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%.

- ***Annual GYN Exam Without Referral*** (managed care plans) - This only affects HMO plans and similar plans. No cost estimate is available. To the extent the PCP would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher. We include 0.1%.

- ***Breast Cancer Length of Stay*** - Our report estimated a cost of 0.07% of premium.

- ***Off-label Use Prescription Drugs*** - The HMOs claimed to already cover off-label drugs, in which case there would be no additional cost. However, providers testified that claims have been denied on this basis. Our report does not resolve this conflict but states a "high-end cost estimate" of about $1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. We include half this amount, or 0.3%.

- ***Prostate Cancer*** - No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. Our report estimated additional claims cost for indemnity plans would approximate $0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately $0.11 per member per month, or about 0.07% of total premiums.

- ***Nurse Practitioners and Certified Nurse Midwives*** - This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- ***Coverage of Contraceptives*** – Health plans that cover prescription drugs are required to cover contraceptives. This mandate is estimated to increase premium by 0.8%.

- ***Registered Nurse First Assistants*** – Health plans that cover surgical first assisting are mandated to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

- ***Access to Clinical Trials*** – Our report estimated a cost of 0.46% of premium.

- ***Access to Prescription Drugs*** – This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.

These costs are summarized in the following table.

Cost of Existing Mandated Health Insurance Benefits

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Indemnity	HMO
1975	**Maternity** benefits provided to married women must also be provided to unmarried women.	All Contracts	0[4]	0[4]
1975	Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts except HMOs	0.1%	--
1975	Family Coverage must cover any **children** born while coverage is in force from the moment of birth, including treatment of congenital defects.	All Contracts except HMOs	0[4]	--
1983	Benefits must include for treatment of **alcoholism and drug dependency**.	Groups of more than 20 except HMOs	0.4%	--
1975 1983 1995	Benefits must be included for **Mental Health Services**, including psychologists and social workers.	Groups of more than 20	3.5%	3.5%
1986 1994 1995 1997	Benefits must be included for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self referred for chiropractic benefits.	All Contracts	1.6%	1.6%
1990 1997	Benefits must be made available for screening **mammography**.	All Contracts	0.3%	0.3%
1995	Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%	0.02%
1995	Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%	0.01%
1996	Benefits must be provided for **maternity (length of stay)** and newborn care, in accordance with "Guidelines for Perinatal Care."	All Contracts	0	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** and approved self-management and education training.	All Contracts	0.2%	0.2%
1996	Benefits must be provided for **screening Pap tests**.	Group, HMOs	.01%	0
1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care	--	0.1%
1997	Benefits provided for **breast cancer treatment** for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	.07%	.07%
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	0.3%	0.3%

[4] This has become a standard benefit that would be included regardless of the mandate.

1998	Coverage required for **prostrate cancer screening**.	All Contracts	.07%	0
Year Enacted	**Benefit**	**Type of Contract Affected**	**Est. Maximum Cost as % of Premium**	
1999	Coverage of nurse **practitioners and nurse midwives** and allows nurse practitioners to serves as primary care providers	All Managed Care Contracts		0.16%
1999	Prescription drug must include **contraceptives**	All Contracts	0.8%	0.8%
1999	Coverage for **registered nurse first assistants**	All Contracts	0	0
2000	Access to **clinical trials**	All Contracts	0.46%	0.46%
2000	Access to **prescription drugs**	All Managed Care Contracts	0	0
Total cost for groups larger than 20:			**7.84%**	**7.52%**
Total cost for groups of 20 or fewer:			**3.94%**	**4.02%**
Total cost for individual contracts:			**3.93%**	**3.92%**

Appendix C: References

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